

Winter 2009

Social Service Needs And Perceptions Of Low-Income Latinos In Metro Denver

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Final Project/Thesis

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SOCIAL SERVICE NEEDS AND PERCEPTIONS OF
LOW-INCOME LATINOS IN METRO DENVER

By

Marissa K. Kaesemeyer

A Master's Thesis Presented in Partial Fulfillment
of the Requirements for the Degree
Master of Science, Health Service Administration

Regis University

December, 2009

FINAL APPROVAL OF MASTER'S PROJECT

HSA696 MASTER'S THESIS

I have **READ AND ACCEPTED**

the Master's Thesis by:

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Submitted in partial fulfillment of
requirements for the
Master of Science in Health Services Administration
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Date: December 2009

Abstract

The Latino population has the highest uninsured rates among all racial and ethnic groups in the United States. Latinos are likely to be poor, and have difficulties accessing social services. The purpose of this study is to understand what social services Latinos need, as well as Latino perceptions regarding access to social services. In order to provide better social services and ultimately maintain good health, it is important for social service organizations to understand their clients' needs and perceptions. The research question is "What are the social service needs of low-income Latinos and how do they perceive access to these social services?" Three focus group interviews were conducted at a parish. The participants were low-income Latinos, 18 years and older, male and female, and residents of Denver. The themes from the data collection were access, negative emotions, social services, qualification, money, and health condition. Access was the most prevalent and important of all themes. The conclusion is that the Latino population is not satisfied with its access to social services. The population finds it confusing to determine the qualifications needed for social services. Educating the population about accessing services, maximizing services and funding available, and creating programs to accommodate current needs and future growth will ultimately enhance the health of low-income Latinos in Denver.

Acknowledgements

Dr. Tristen Amador
Regis University
Assistant Professor/Faculty Research Advisor

Dr. Maureen McGuire
Regis University
Associate Professor/ Faculty Research Advisor

Dr. Shelia Carlon
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Director/Professor/ Faculty Research Advisor

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Chapter 1. Introduction

Introduction to the Problem

Denver, Colorado contains several ethnic groups including Whites, Blacks, American Indians, Native Alaskans, Asians, Native Hawaiians, and Hispanics or Latinos. One of the largest ethnic groups is Latinos. According to the U.S. Census Bureau, in 2007 Denver's population was 566,974, and approximately 37% was Latino. Between 1990 and 2005, influxes of immigrants came to Colorado and other southern states to work in food processing, construction, and other fields (Ku, 2007). Although this population has a good work ethic and high employment rate, access to affordable healthcare is challenging (Ku, 2007). "Low wage workers are less likely to be offered health benefits or to be able to afford the employee's share of premiums when they are offered coverage" (Kaiser Commission, 2000). According to the Kaiser Commission on Medicaid and the Uninsured (2000), the Hispanic population has the highest uninsured rates among all racial and ethnic groups in the United States. In addition to high uninsured rates, Latinos are likely to be poor and ineligible for healthcare programs such as Medicaid depending on their legal status (Ku, 2007).

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), enacted in 1996, was signed to help end welfare. Latinos entering the country after 1996 were affected by PRWORA, as the act states these non-citizens are not eligible for Medicaid (Kaiser Commission, 2000). Those who are eligible often fear applying for Medicaid, because they worry it may "jeopardize future citizenship or that they will be forced to repay Medicaid costs" (Kaiser Commission, 2000, p. 1). If Latinos are illegal citizens, they are potentially ineligible for public social services such as Temporary Assistance for Needy Families (TANF), which was

instituted by PRWORA, as well as the low-income energy assistance program (LEAP) and food stamps. In order to qualify for these social services one needs to prove U.S. citizenship.

In addition to inadequate healthcare coverage, poverty, and potential ineligibility for social services, Latinos face other barriers. Ku (2007) states that “immigrants and their families may experience additional difficulties with the American healthcare system brought on by language barriers, cultural misunderstandings, and differences in legal rights that are not experienced by those from native-born families” (Ku, 2007, p.413).

Another concern is stigma. “Stigma unfortunately is often accompanied by apprehensions and distrust about service use because of historical abuses, lack of familiarity with systems, and experiences with mental health professionals who are not culturally competent or sensitive” (Goldston, Mollock, Whitbeck, Murakami, Zayas, and Hall, 2008, p. 13). Also, lack of bilingual staff and interpretation services tends to create barriers for Latinos as well. These barriers, in addition to the growing and aging Latino population and the relatively low social economic status (SES) of Latinos are all factors that compromise Latino’s health and well-being.

Purpose and Research Question

The purpose of this study is to understand what social services Latinos need, as well as Latino perceptions regarding access to social services. In order to provide better social services and ultimately maintain good health, it is important for social service organizations to understand their client needs and perceptions. Therefore, the research question is: What are the social service needs of low-income Latinos and how do they perceive access to these social services?

Rationale

It is important for social service organizations to understand their client population so they can provide quality care, prevent disease, and promote a healthy lifestyle. Latino

immigrants are vulnerable, so improving our knowledge of this population will allow social service organizations to better meet their needs. Ku (2007) states in his study that poor Latino immigrant families face hardships other than access to healthcare. Also, Ku (2007) notes:

Latino immigrant families experience more hardships such as crowded housing, food insecurity (including hunger), or unmet medical needs than other families, even Latino citizen families. Even among families with incomes below the poverty line. Latino noncitizen families experienced more hardships than others. These conditions—poverty, crowded housing, poor nutrition, and poor access to care—can contribute to health problems for immigrant families (p. 413).

In addition to understanding the demographics and culture of the Latino population, it is also important for healthcare professionals to understand the specific social needs of the recently immigrated Latino population. Furman and Negi (2007) state:

This restriction of basic social, health and educational services adds to the marginalization of this population and its future generations. The exclusion or restriction of social services with this population can be detrimental to the U.S. health as well, since the offspring of these migrants are often born in the USA and are American citizens (p. 110).

Understanding Latinos' social needs will benefit their well-being. Furthermore, access to social, health, and educational services benefits the overall health of this population, as well as the overall health of the U.S. (Furman & Negi, 2007).

The overall health of the Latino population is inhibited by the lack of the essentials to live a healthy life. In the past, good health has been characterized by having good healthcare and

access to medication (LaLonde Report, 1974). However, in 1974, a report by Marc LaLonde challenged this tradition. He stated that there are four quadrants to health, and that healthcare and medicine alone are not determinants of health (LaLonde Report, 1974). The four quadrants to health are human biology, environment, lifestyle, and health care (The LaLonde Report, 1974). A deficiency in one quadrant affects a person's overall health (The LaLonde Report, 1974). LaLonde's report explains that access to social services is as important as access to healthcare.

In response to LaLonde's report, the World Health Organization (WHO) adopted LaLonde's four quadrants, and called a meeting to "promote and protect the health of all people in the world" (Declaration Alma-Ata, 1978, p. 1). In 1978, the Declaration of the Alma-Ata stated that primary care "involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors" (Declaration Alma-Ata, 1978, p. 2). LaLonde's report and the Declaration of Alma-Ata contain concepts adopted by countries around the world. It is important for U.S. healthcare professionals to include these concepts to maintain the health of the country. Implementing these concepts in social service programs in an effective manner may benefit the clients and healthcare professionals.

An equally important topic is that the healthcare industry has experienced a shortage of healthcare professionals in certain geographic areas. Maldistribution typically occurs in rural areas, which is where many low-income clinics are located and many Latinos reside. Physician shortages in rural areas are a result of long working hours, requirements to be on call, smaller financial rewards, professional isolation, and reduced quality of life (Shi & Singh, 2008, p. 131). Casey, Blewett, and Call (2007) stated:

Latino's access problems also reflect larger systematic problems in rural healthcare, such as shortages of physicians and other healthcare professionals (including bilingual professionals and qualified medical interpreters) and reluctance on the part of many dentists and some physicians to participate in Medicaid and the State Children's Health Insurance Program (SCHIP) (p. 1710).

Rural healthcare professionals have difficulty providing quality care since they lack funding from federal healthcare programs. Especially necessary is funding for language assistance, interpreter services, and safety net services. Because of the lack of healthcare access in rural areas, it is important for health services administrators to streamline inefficiencies within healthcare organizations in order to render quality services.

One way to eliminate these inefficiencies is to employ social workers, case managers, or have a social service department. These measures will help promote access to social services. If the organization relies on social workers to educate clients about available social services, it is important that their caseloads are manageable and that they are fluent in the available social services. "Patients also indicated that systematic problems such as high caseloads or caseworker turnover complicated their efforts to learn about services" (Anderson, Halter, & Gryzlak, 2004, p.5).

Implication of the Research Problem

This research topic is important, because the success of healthcare organizations often depends on the organizations' ability to aid their low-income patients in accessing social services. Quality care means not only providing medicine and healthcare, but also providing the

basics necessary to sustain a healthy life. Health services administrators have a responsibility to help their low-income patients obtain information in accessing social services.

Financially, if health services administrators help Latinos access social services, there will be less wear and tear on hospitals and healthcare professionals because the Latino population will be healthier. Also, the more integrated into the healthcare system social services are the more efficient they will be. As a result, hospital services will be utilized less, as Latinos will be healthier and seek healthcare services at locations that suit their needs.

Chapter 2. Literature Review

Latinos are a vulnerable population because they typically have low socio-economic status (SES) which contributes to difficulty in accessing social services. Statistics show that Latino immigrant families experience more socio-economic hardships than any other immigrants (Ku, 2007). Many of the hardships Latinos face are directly related to their socio-economic status, such as lack of formal education, lack of employment, and lack of sufficient healthcare. According to Denver Health and Human Services, approximately 14% of Denver's population is below 100% of the poverty level (2009). Across the United States, 21.9% of Latinos live in poverty which translates into every 1 in 5 Latinos (Behavioral Risk Factors Surveillance Survey, 2004). In the Harvard Health Letter (2003) the fellows stated:

One truism of health research is that socioeconomic status matters. As a rule, the less education you have and the less money you earn, the shorter your life expectancy and the greater your chances of getting many diseases. Poor access to healthcare is partly to blame. People with less education are more likely to be exposed to unhealthy conditions at work. In general, poverty and related circumstances are associated with high stress levels that are bad for health (p.3).

The Latino population is below average in education, income, health coverage, and access to healthcare (Harvard Health Letter, 2003). In addition, exercise and obesity are behavioral risks for the Latino population (Harvard Health Letter, 2003). However, statistically Latinos are healthier than the white population. This is called the Latino paradox (Harvard Health Letter, 2003). Experts believe the calculated mortality rate for Latinos may not be accurate because they leave the country to die. Also, Latinos are looked at as a single national origin, when in reality

there are several different ethnic groups that fall under the “Latino” umbrella (Harvard Health Letter, 2003).

In addition to low SES, there are also other barriers that effect the Latino population when accessing social services. These include language, discrimination, rural access, state and federal policies, lack of health insurance, and family dynamics. The problem is that there is little research on the needs and perceptions of low-income Latinos about accessing social services in metro Denver.

History of Latino Immigrants in Denver

America is a nation of immigrants which have come in different waves. Initially, Latinos came during the end of the nineteenth century and the early twentieth century (Pedraza, 2000). There are many ethnic groups that fall under the name “Latinos”. Mexican Americans, South/Central Americans, Puerto Ricans and Cubans all have different cultures but a common language. “Mexican Americans account for 66% of the total Latino population living in the U.S., followed by South/Central Americas at 14%, Puerto Ricans at 9%, Other Latinos at 6% and Cubans at 4%” (Wallace & Villa, 2003, p. 248). Among the various ethnic groups, the elderly Mexican Americans are the largest, and reside in the Southwest (Therrien & Ramirez, 2000). Typically, Latino immigrants settled in California and New York before the 1990s; however, since the labor boom in food processing, construction, farming, and other fields, opportunities were marketed to Latino immigrants, and they settled in states like Georgia, North Carolina, Colorado, and Nevada (Ku, 2007). Latinos were known for cheap labor, so this population grew quickly in the early twentieth century in Colorado, as sugar beet farms were prospering (Donato, 2003).

Since Latinos arrived in the U.S., because of their minority status, they have experienced discrimination, and anti-immigrant sentiments at one time or another (Flaskerud & Kim, 1999).

Flakserud & Kim (1999) stated that in California,

there was a social and political climate directed against some Asian and Latino groups that is evidenced in voter-approved measures to restrict healthcare, education, equal opportunity, and language use. Obviously conditions such as these have an enormous effect on immigrant health, as well as the public health (p. 360).

As a result of the high-population growth of Latino immigrants and the many social challenges they face, health and social systems that serve the Latino community are often overwhelmed (Ku, 2007).

Social Services and Health

Low-income Latinos face health disparities derived from their low SES. For example, the Center of Disease Control (CDC) reported in 2003 that Hispanics age 65 years and older received less flu vaccines than whites 65 years and older. Forty-five percent of Latinos received the flu vaccine compared to 69% of whites, and the flu vaccine is covered by Medicare (CDC, 2007). Some Latinos, however, do not have access to Medicare especially if they came to the U.S. after 1996.

Also, during 2001–2004, the CDC reported Latinos as having the highest rate of AIDS diagnoses. Eighteen percent of new HIV/AIDS cases were of the Latino population (CDC, 2007). The statistic identifies a percent increase in HIV/AIDS cases that is alarming, and improving access to education and social services would decrease this high percentage. Combating health disparities will increase the overall health and well-being of the Latino

population. This can be done by improving access and providing quality social services to fit their needs.

Access to social services improves health status, as social services give the essentials to the needy to survive (Galea & Vlahov, 2002). For example, a reduced SES results in poor health. Galea and Vlahov's (2002) study researched adverse health consequences of drug users. Interestingly, drug users share some common social factors with low-income Latinos such as homelessness and low SES (Galea & Vlahov, 2002). Galea and Vlahov stated that in numerous studies the homeless face hardships such as high rates of mortality, mental health disorders, and infectious diseases (Galea & Vlahov, 2002). They also found that a decrease in mortality and morbidity are directly related to an increase in income and education (Galea & Vlahov, 2002). As a result, there seems to be a consensus about how certain social factors affect health (Galea & Vlahov, 2002). Simply put, the poorer an individual is, the more likely that individual is to suffer adverse health consequences.

Homeless families are at particular risk in regards to their health. This fact is especially alarming considering the current economic climate. According to the Colorado Coalition for the Homeless, a non-profit organization that strives to defeat homelessness, there has been a record number of homeless clients in 2008 due to economic hardships (Colorado Coalition for the Homeless, 2009). Also, the Coalition's Stout Street Clinic "has seen a 16% increase in patient visits over the past year, and has been forced to put more than 120 homeless persons seeking mental health services on a waiting list" (Colorado Coalition for the Homeless, 2009). As economic conditions worsen, the ability to provide quality social services becomes more limited due to increased reliance upon these resources and financial constraints.

Chiriboga, Black, Aranda, and Markides (2002) conducted a study on depressive symptomatology in elderly Mexican Americans in the Southwestern United States. The researchers looked at several factors that are associated with depression among the elderly Mexican Americans and found that “death, illness of family members, and financial problems were the top factors leading to depression” (Chiriboga et al., 2002). These factors are all exacerbated by low SES.

As a population, Latinos have a relatively low SES. As a result, Furman and Negi (2007) contend that all Latino migrants should be eligible for basic social, health, and educational services. If they are not eligible, it hurts the health and the positive growth of our nation (Furman & Negi, 2007). A good portion of immigrant Latinos have U.S. born children, therefore it is important to provide them with what they need to be a part of our society (Furman & Negi, 2007). Furman and Negi believe that it is important to provide multi-functional services to cater to all immigrants and their needs. This supports the idea that social services are especially important to at-risk populations. Low-income populations need social services to grow and become useful in our society.

Barriers to Accessing Social Services

Several barriers preventing Latinos from accessing social services are worth mentioning. Some of these barriers include: language, discrimination, limited rural access, state and federal policies, lack of health insurance, and family dynamics.

The study of vulnerable populations and the effects of language were most prevalent among the research. Diaz, Roberts, Goldman, Weitzen, and Eaton (2008) studied the effects of language on colorectal cancer screening among Latinos and non-Latinos. The results of the study showed that Spanish-speaking Latinos had less access to colorectal cancer screenings compared

to non-Latinos that responded in English. The study suggests that Spanish-speaking Latinos may be discriminated against when testing for colorectal cancer (Diaz et al., 2008). This is important to acknowledge, as the Spanish language is widely and exclusively used among many low-income Latinos.

Similarly, Folsom et al. (2007) assessed ethnicity and language when rendering mental health services to Spanish-speaking Latinos, English-speaking Latinos, and English-speaking Caucasians. Folsom et al. researched how the effects of language on mental health service differed for each group. The results were different from what the researchers hypothesized. The researchers initially believed that the Spanish-speaking patients would not utilize mental health services as much as the other two groups. Instead, the Spanish-speaking group utilized mental health services just as much in some cases, and less in others. This indicates that language affects the way Latinos access mental health services, but does not provide a clear indication of what that effect is. Their conclusion stated that language was more important than ethnicity when accessing mental health services (Folsom et al., 2007).

Equally important, Kretsedemas (2005) conducted a study on language barriers and perceptions bias with the welfare system in Florida. He found that it is important for social resource organizations to provide information in the language of their client, as it allows the clients to become self-sufficient. The study found that welfare needs were not adequately met by bi-lingual caseworkers, as there were differences in Spanish-speaking clients and the fluency of the caseworkers (Kretsedemas, 2005). The study also found that the Spanish-speaking group had different needs, as they were from different areas of the world (Kretsedemas, 2005). Overall, language barriers were an issue when accessing welfare for immigrants as there was a lack of trained bi-lingual caseworkers as well as a lack of translation services available. As a result,

immigrants had a difficult time receiving services (Kretsedemas, 2005). Having enough competent bi-lingual healthcare professionals and understanding the different ethnic groups that speak Spanish is important in providing quality services.

In addition to language, discrimination is another barrier faced by Latinos when accessing social services (Ku, 2007). Ku discusses the fact that language and low SES status may cause discrimination, and for this reason Latinos purposely do not utilize services, as they fear deportation (Ku, 2007). Since discrimination is known to affect health and well-being, it is significant to include in the research (Galea & Vlahov, 2002). Discrimination is also prevalent when Latinos access healthcare services, especially if they do not have health insurance coverage.

In addition to challenges in identifying the needs of Latinos, there are also legislative barriers to accessing social services for low-income clients. For example, the Department of Health & Human Services (2009) stated in the Next Phase of Welfare Reform: Implementing the Deficit Reduction Act of 2005 that PRWORA of 1996,

dramatically changed the nation's welfare system into one that requires work in exchange for time-limited assistance. PRWORA contains strong work requirements combined with supports for families moving from welfare to work, including increased funding for child care, continued eligibility for medical coverage, state maintenance of effort requirements and comprehensive child support enforcement provisions (§ 1).

A budget is given for all states to provide limited cash assistance for needy families, with an emphasis on employment (Gooden, 2006). Also, in regards to the state maintenance of efforts requirements, the state receives federal money to help assist with payment for Medicaid services

(National Health Law Program, 2009). Therefore, the states are responsible for developing and operating their own Temporary Assistance for Needy Families (TANF) program. “In some instances, it allows states and localities to tailor services to meet the unique needs of the immigrant populace. In others, the autonomy is a significant financial burden in areas with high immigrant populations” (Angel, 2003, p. 85).

PRWORA is a threat to elderly Latino immigrants because of the entrance provision; if they entered the country after August 22, 1996, they are not eligible for social security coverage and are not likely to qualify for Medicare coverage (Angel, 2003). “According to the U.S. Census Bureau in 2000, 4.9% of Latinos in the U.S. were over the age of 65 years old. Indeed, the Census Bureau projects that while the non-Latino white population age 65 and older will increase by 81% the Latino population age 65 and older is expected to increase 592% between 2000 and 2050” (National Institute of Health, 2009, p. 247). Medicare is important to elderly Latino immigrants, as it will provide long-term care and home care (Angel, 2003). PRWORA is limiting the social services available, which negatively affects the Latino population.

In addition, health insurance is another barrier preventing low-income Latinos from accessing social services. Casey et al. (2004) analyzed three Midwestern communities’ access to local health systems and found that many of their needs were unmet due to lack of health insurance. According to Kaiser Commission on Medicaid and the Uninsured (2000), “Latinos are reported to have the highest uninsured rates in the United States” (Kaiser Commission, 2000, p.1). If Latinos are underinsured, it is typically inadequate and it is not user friendly (Ku, 2007). Overall, the lack of health insurance among Latinos is important to assess, so healthcare professionals can guide Latinos in the right direction to obtain social services.

Finally, the last barrier is family dynamics. Padilla, Radey, Hummer, and Kim (2006) studied Latino children of unmarried immigrant mothers in the United States and found they face many hardships in comparison to children of U.S. born mothers. Latino children are more likely to face higher poverty rates due to a lack of education and employment within their families. Also, they lack access to social services (Padilla et al., 2006). Since both parents are not U.S. citizens they are unlikely to receive public aid. Understanding family dynamics and hardships unique to the Latino population will help healthcare professionals guide clients to the social services in which they qualify. However, children born in the U.S. regardless of the legal status of his or her parents are eligible for SCHIP (Child Health Plan Plus, 2009).

Latino Needs

Kim, Cho, Cheon-Klessig, Gerace, and Camilleri (2002) researched the underserved Korean immigrant population in Chicago. Research was conducted over 4 years to determine the mental health needs of the Korean population and to provide quality services and achieve better outcomes (Kim et al., 2002). According to the researchers, acculturation is important in order to immerse into American culture and society (Kim et al., 2002). Also, they found that once the Koreans became more acculturated, there were fewer cases of mental disorders, and they understood the resources that were accessible to them (Kim et al., 2002). The study found that it is important to understand the needs of the underserved Korean population, in order to help them utilize the social services available to them. Understanding the needs and utilization of services will benefit this population's health. This study's methodology and findings could be applicable to this study.

This research explains how organizations can be successful by determining the needs of their clients. Determining this information will help an organization run efficiently and maximize

budgets. This study relates to the researcher's topic, as it shows how other immigrant populations are integrating in American culture and society. Like the Koreans, it is important to identify the needs of Latinos to better serve them.

Riffe, Turner, and Rojas-Guyler (2008) researched the Latino population in the Midwest to identify the population's needs in order to provide higher quality services. The researchers discovered that social work professionals and community planners would be needed to help promote a healthy community. Each community may be dealing with a different culture even though they are from the same country, as cultural differences can be regional. "Latinos are typically lumped into an all inclusive "Hispanic" category; however, cultural norms and even language can vary widely by country of origin" (Riffe et al., 2008, p. 102). Determining specific cultural needs is significant as it allows a social service program to fit the exact needs of their clients.

Strug and Mason (2001) conducted a qualitative study in Washington Heights, New York on the needs of Latino immigrants in regards to access to social services. Strug and Mason discovered that the need for affordable housing and affordable healthcare were the two main concerns among Latino immigrants (Strug & Mason, 2001). Like the low-income Korean population mentioned previously, acculturation seemed to be an issue among Latino families (Strug & Mason, 2001). For example, there is a stigma with mental health services in Latino culture. Stigma can be a result of financial and social barriers. "[Mental health] service use by minorities was more affected by financial and social barriers (e.g., stigma)" (McGuire and Ojeda, 2006, p. 1) Researchers have found that "depressed Latinas and African Americans are significantly less likely than whites to obtain mental health care, even after controlling for other factors likely to affect use of services" (McGuire and Ojeda, 2006, p.9). Considering this

finding, this also could be a result of cultural beliefs. Also, most Latino immigrants deal with their health concerns in other ways than seeking medical attention, as they have little or no health insurance and they have different cultural beliefs (Strug & Mason, 2001). The researchers also reported that Latino immigrants deal with hardships considering they speak little English. Because of this, they are less acculturated, have a misunderstanding of the bureaucratic system, and also face discrimination (Strug & Mason, 2001).

To conclude, there is research showing that social services helps to maintain good health in low-income populations. Also, research is available on how SES status affects health and well-being. Much of the research identified the barriers that affect low-income populations in accessing social services. However, there is a paucity of information in regards to needs and perceptions of Latinos about accessing social services, particularly in Colorado. This paper investigated the perceptions of Latinos regarding access to social services and what their actual social service needs are.

Chapter 3. Methods

Method

The researcher studied low-income Latinos in metro Denver, and specifically their perceptions about accessing social services and needs. Little research has been performed regarding the needs and perceptions of Latinos in Denver; therefore, this research is important as it is useful for social service organizations. This study investigated what the Latino population experienced when accessing social services.

The qualitative method was utilized to conduct the study. A qualitative study is a study of words. The researcher's assumptions shaped the study and helped determine what the researcher needed to complete its findings (Liamputtong and Ezzy, 2005). This qualitative method is appropriate for the researcher's study, as it allowed the researcher to interpret her population's lived experiences in accessing social services and each of her participants influenced the other to share their experiences.

Research Design

The research design was focus groups. Focus groups are group interviews that rely on interaction within the group of participants to collect data. This was the primary research design. "The hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group" (Morgan, 1997, p. 2). Focus groups were utilized as a self-contained method, which means that it was the only method utilized for this study (Morgan, 1997).

Sampling Strategy

Denver Inner City Parish (DICP) was the research site where the researcher recruited the focus group participants. DICP is located in West Denver and provides services to low-income

people around metro Denver. DICP has several programs such as the Emergency Food Bank and Parish Senior Center Program. The Emergency Food Bank provides food to the needy. The Parish Senior Center Program is a place for the elderly to have a meal and conversations. Also, DICP developed the Parish Senior Center Program to educate the elderly on health and social well-being. This site was chosen because the highest percentage of Latinos in metro Denver resides in this area. Also, DICP has a high concentration of Latinos accessing the agency's services.

The researcher received written permission from the Executive Director of DICP to obtain access to the Latino population that utilizes these programs. About 60% of the Latino families that utilize the services at DICP live within walking distance, and 40% commute from around the metro Denver area. This research was conducted at DICP so the participants were in their natural environment.

The sample included male and female low-income, English and Spanish-speaking Latinos that live in the metro Denver area. Each group came from the different programs at DICP. Three participants came from the Food Bank and nine were recruited from the Parish Senior Center. This allowed the researcher to reach saturation. The sample was purposeful and small which are characteristics of a qualitative study.

The researcher visited DICP before the research started to become acquainted with the organization, as well as the Executive Director. Also, a flyer was created to recruit the participants within DICP. The flyer included study title, the basis for participant selection, the name of the researcher, the location of the study, and Regis's name (see Appendix C). Also, the Executive Director introduced the researcher in front of several audiences to help gain credibility. Before the date of the focus group interviews, the researcher had the Executive

Director contact the participants to remind them. Prior to the interview, participants signed a written consent form approved by Regis University's Institutional Review Board (IRB). Each participant received a copy of the consent form after they completed the form. The consent form stated why the prospective participant had been recruited and that there were no potential risks. Also, the consent form stated there was no compensation provided to the individual, but that there was confidentiality regarding the data and the participant. To ensure confidentiality, the researcher assigned each participant a pseudonym. After transcription was completed, the researcher stored the audio-tape recordings in a locked file cabinet. The data was kept in a password protected computer.

The goal of the researcher was to obtain the most effective information in order to answer the research question and conclude the study. Once the researcher obtained approval from Regis University's IRB and recruited enough individuals, the researcher started the process of data collection.

Measurement Strategy

The researcher conducted interviews through focus groups to obtain data for the study. The researcher was the moderator who asked interview questions and guided the interaction among the participants after the consent form was signed (see Appendix A). The note taker provided a thick description by describing the physical setting and behaviors and writing down field notes. The notes included information about time, place, and date of the field setting where the observation took place (Creswell, 2007).

The focus group interviews were informal and lasted between 45 minutes to an hour. The researcher utilized an interview guide with interview questions pre-determined by the researcher and the researcher's advisor. A quiet room was reserved, so that there were no distractions with

the audio-tape. The researcher worked with the Executive Director to reserve a room, chairs and tables.

Method of Analysis

The method of analysis was content analysis. In starting the process, the researcher utilized the constant-comparative method, collected data and transcribed simultaneously. Once the researcher had completed the first round of interviews with the first focus group, she transcribed the data by typing it into a Word document. The first part of content analysis started with data management. The researcher organized the data into Word document files (Creswell, 2007). Each interview was transcribed after they were completed. Throughout the data analysis the researcher followed Creswell's (2007) steps to data analysis and representation. After the data collection and transcription process was completed, the audio-tapes were locked in a file cabinet at the researcher's home and the Word documents are held confidential through the researcher's personal computer with a password.

The second step in the content analysis process was to read and reread all transcribed notes and analyze and explore the data retrieved (Creswell, 2007). During the second step, the researcher assigned pseudonyms to the participants to maintain confidentiality. The third step was describing, classifying, and interpreting the data (Creswell, 2007). "Here researchers describe in detail, develop themes or dimensions through some classification system, and provide an interpretation in light of their own views or views of perspectives in the literature" (Creswell, 2007, p. 151). During this step, the researcher started to code the data, which is the "describing" part of the process. The researcher broke the codes down into a classification system, or themes, and created a codebook. Also, to ensure inter-coder reliability, the coding was reviewed by a second party, and the inter-rater reliability was calculated. The *Cohen's Kappa* was 71 percent.

Next the researcher interpreted the data (Creswell, 2007). Once the data was interpreted, the researcher made conclusions from the results and presented the study to help the audience understand the lived experiences of the participants in the study.

Chapter 4. Results

The researcher, the director of the Parish Senior Center program, and the director of the Emergency Food Bank at DICP recruited 12 participants over three months. Each participant was low-income Latino, 18 years and older, a metro Denver resident, and had experience with accessing social services. The participants consisted of two males and ten females. One female participant only spoke Spanish, and the other participants were either bi-lingual or only spoke English. The researcher had the director of the Food Bank translate for the Spanish-speaking participant. This interview was then transcribed by the researcher.

The data was derived from three focus group interviews and revealed several themes. Some of these major themes aligned with the literature review. The major themes from the data collection were access, negative emotions, social services, confusion regarding qualification, money, and health condition. Access was the most prevalent and important of the themes, as all participants experienced difficulties accessing social services. Also, the other themes frequently linked back to access. Several participants explained in the interview that there are clinics to go to when you need help; however, those clinics are often crowded and it is extremely difficult to obtain an appointment. In order to obtain an appointment, a patient must call early in the morning and usually is unable to see a doctor no matter what the urgency. For example, the question asked was “What are your experiences with accessing social services?” One participant stated, “You call the hospital to get an appointment and you can’t get in.” Another participant stated, “I can’t get in with gastric bypass surgery. Call back tomorrow. Call back.” The two participants explained that they were not able to obtain an appointment for many different reasons, and were also frustrated. Access and negative emotions were themes found in response to this question.

In the literature review, ineligibility was a common barrier in accessing social services. Ineligibility was a barrier in this study, but it applied only to the undocumented participant from Mexico. The rest of the participants did not face legal barriers associated with eligibility, as they are U.S. citizens. Also, ineligibility can be a result of low income families making too much money, but not enough to pay for healthcare benefits. One participant experienced this, as she had a job, but could not afford the premium of her employer's healthcare insurance. The rest of the participants had Medicaid or Medicare to assist with obtaining health services.

Negative emotions were another theme of the data collected. All participants expressed negative emotions in regard to accessing social services. For example, one participant said, "They (a hospital) make you feel like you are not good enough for this society." Another stated, "I don't want to try anymore". She was exhausted from applying and waiting to receive food stamps. Both participants expressed each experience with a negative tone. Other key words in the data that signified negative emotions were frustrating, upsetting, sad, dislike, bad, and hard.

In the literature review, the researcher found that discrimination was a barrier to access, which also falls under the theme of negative emotions. A few of the participants stated that lack of access was associated with discrimination. One participant stated that staff at the food stamp office were inconsiderate and disrespectful and she felt it had to do with her social status. Another participant confronted a caseworker since she felt she was treated differently due to her Latina ethnic background.

Another barrier in the literature review that is linked to negative emotions was lack of trained staff at social service organizations. This barrier manifested itself in the participants' stories. For example, a few participants expressed frustration when applying for food stamps. The personnel treated them poorly and were not helpful. Also, another participant mentioned a

time when she went to the clinic when she was sick. A poorly trained nurse called her back after the visit with her diagnosis, but was not able to explain the illness and the next steps for treatment.

Social services were an obvious theme, as the interview questions were tailored around accessing social services. Each participant had accessed social services at some point in their life. The most common social services utilized were food stamps, healthcare, low-income housing, and dental services. However, most participants were confused about eligibility, and which services were accessible to them. For example, “I thought that after you reach a certain age you qualify for Medicare and Medicaid. Every time I go to Colorado Indigent Care Program (CICP), they tell me I do not qualify for Medicare. I am 72 years old.” Another participant was confused regarding whether Medicaid covers dental work. She stated, “Apparently there are different types of Medicaid. I talked to one friend and they have the same Medicaid and it pays half of it (dental work).” Also, the participants wondered how often they needed to apply for social services.

Confusion with qualification also aligned with what the researcher found in the literature review. This common barrier was mentioned by all the participants, and is a symptom of the complexity of the U.S. healthcare system. Participants cited confusion regarding qualifications, where to obtain specific services, and the cost of services.

In addition to confusion regarding qualification for social services, the expense was another frequent concern. One participant stated that her blind sister received less in food stamps than she did. The participant stated that receiving more food stamps than her blind sister seemed unfair, as she was working full time and was not disabled. “They were giving her 10 dollars a month, and I was receiving 200 dollars a month”. Another example of the money theme was evident when a participant explained, “It doesn’t make sense when you need a tooth extracted

and they won't do it because they pulled one already. Sometimes students will do it and it is cheaper. But I can't afford that, I can't afford anything". Many participants had issues accessing dental work, were unable to afford extra services, and were not sure if they qualified for, or where to obtain the services.

Health condition was the final theme of the data collection. This theme was included because most of the participants had some type of ailment such as flu, dental needs, diabetes, back pain, and epilepsy. One of the participants experienced epileptic attacks, and her only option is to go to the emergency room because she has no health insurance. The total bill for one night was \$6000, which is more than what she and her husband can afford. If she had health insurance, this bill would likely be more manageable. Another participant had a tooth extracted and thought she needed another. "You can only get one tooth pulled a year. I needed some pulled out and since they pulled one already, they wouldn't pull another." Lack of or limited access to healthcare is one reason these participants suffer from their ailments. Also, most of the participants stated that even if there is access, it is difficult to obtain an appointment.

Some of the barriers found in the literature review did not apply to this study. These barriers are transportation concerns, lack of bi-lingual healthcare professionals, cultural misunderstandings, and family dynamics. The participants in this study did not experience transportation or language barriers when accessing social services. This is a result of the data collected in metro Denver. Also, most of the participants were English-speaking or bi-lingual except for one who only spoke Spanish and reported no difficulties with language barriers when accessing social services. In addition, family dynamics were not a barrier among the participants in this study, as the majority of the participants were U.S. born. According to the literature review, U.S. citizens have fewer access issues compared to foreign born.

Chapter 5. Discussion, Recommendations, and Conclusions

Discussion

The research question asked, “What are the social service needs of low-income Latinos and how do they perceive access to these social service?” This study provides data that reflects how low-income Latinos feel about accessing social services and their needs for those services. The needs of the low-income Latino population include: 1) increased access to healthcare services, 2) increased access to dental services, and 3) education on social services availability and eligibility. With the exception of the undocumented Latina, this population accessed social services; however, that access is limited. Most participants experienced negative emotions before and after accessing social services. The negative emotions were a result of lack of respect, limited access, their health conditions, lack of affordability, and confusion regarding qualifications for social services.

The major issues identified will be minimized if health services administrators incorporate this information into the planning of current and new programs. The conclusions of this study will help health services administrators tailor their services based on need and to maximize services and funding available. Improving the quality of social services provided to the low-income Latino population will help the overall health of the community, and provide the basics necessary to sustain a healthy life in this growing population.

Health services administrators can maximize services available to low-income Latinos by creating new programs and partnerships with other organizations that provide social services specifically to the Latino community. Also, there will be less wear and tear on hospitals and healthcare professionals because the Latino population will be healthier and will seek appropriate

services for their needs. Finally, the more integrated into the healthcare system social services are, the better the utilization of funds and services.

This research project has not solved the problems of access and quality of social services provided. However, this project has revealed information that healthcare organizations can take into consideration in order to improve services. Access clarification and education regarding qualifications for obtaining services are two ways to increase the satisfaction and the health of the low-income Latino population. Once these steps are implemented, the negative emotions associated with access and confusion regarding qualifications for obtaining services will decrease. Also, the severity of health conditions will decrease due to increased access. The theme of cost will unfortunately be a constant battle; however, if strategies are implemented to fix the concerns of access and qualifications this could streamline the system and potentially reduce cost.

Limitations

This project was limited by the size of its sample population, age, time constraints, and level of experience. The Cohen's *kappa* for this study was 71 percent, which is acceptable (Neuendorf, 2002). This percentage indicates that this study is reliable and valid (Neuendorf, 2002). However, the researcher cannot generalize to the larger population because of the small sample size, but that this information can be transferred to a similar population. A larger population would have provided more experiences with accessing social services and therefore more reliable results.

The researcher observed that most of the participants were over 35 years old, and the results could have been different if there was a wider age range. In addition, the researcher's level of experience could have affected the study. For example, this is the researcher's first time

with coding data. Typically, professional researchers are thoroughly trained on coding transcriptions (Neuendorf, 2002). Lack of experience is a threat to reliability (Neuendorf, 2002).

Interestingly, the researcher anticipated finding more examples of individuals facing legal barriers to accessing social services, but only one participant did not have access to healthcare due to their undocumented status. This outcome may have been a result of the population size and recruitment from one site. Also, most of the population was U.S. born.

Recommendations

Limited access to dental services and the inability to obtain appointments were common complaints among the participants. The researcher recommends that more dental services should be made available to this population, as well as information about where to access dental services in the metro Denver area. In addition, extending clinic hours will accommodate more patients in need of health care. This may result in a reduction in emergency department visits by this population, as well as increase the likelihood of obtaining an appointment for health care services. In addition, clinics should provide information on preventative care, as most of the participants in this study had an existing health condition. By extending clinic hours, clinics can provide classes on how to prevent diseases common in this population, such as diabetes.

The participants' negative emotions towards accessing social services could be reduced by providing customer service training to employees at social service organizations. Providing these employees with the appropriate tools, materials, and training will help address the lack of respect reported by the participants, and also resolve confusion about qualification and accessibility.

The researcher recommends a hotline or one-stop resource center where low-income Latinos can seek information on eligibility for social services. This will provide the population

with information about available resources, the qualifications necessary to access those resources, and service locations. The implementation of a hotline or resource center will help the population take advantage of existing social services.

Conclusions

Further research needs to be conducted on the low-income Latino population, as it continues to grow and remains vulnerable. A study of a larger population over a longer period of time would be beneficial, as it would increase validity and reliability. In addition, the data collection should be conducted in surrounding counties of metro Denver, as the low-income Latino population is spreading into these counties as well (U.S. Census Bureau, 2009). The conclusion is that the low-income Latino population is not satisfied when accessing social services. Also, their needs are not met, which was emotionally draining to the participants in the study. In addition, most are consistently confused about their qualifications for accessing social services. In conclusion, educating the population about accessing services, maximizing those services and funding available and creating programs that will accommodate current needs and future growth, will ultimately enhance the health of the low-income Latino population in Denver.

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Appendix A.

Interview Guide

1. Do you utilize any type (s) of social services?

If no, why not?

If yes, what types of social services do you utilize?

If yes to accessing social services, tell me about your experiences with accessing: food, healthcare, shelter, education and heat.

2. What are your primary reasons for accessing social services?

3. How often do you access social services?

4. Where are these social services located?

5. What types of transportation do you utilize to access social services?

6. What emotions do you experience before you access social services?

7. What emotions do you experience after you access social services?

8. What needs were met?

9. What needs were unmet?

10. Have you experienced challenges when accessing social services?

If yes, tell me about the challenges you faced when accessing social services.

11. What are some positive things you can say about accessing social services in Denver?

12. What is important to you when accessing social services?

Appendix B.

Informed Consent Form***Invitation to Participate***

You are invited to participate in a research study titled: Social Service Needs and Perceptions of Low-Income Latinos in Metro Denver conducted by Marissa K. Kaesemeyer, a student from Regis University, Department of Health Services Administration, under the direction of Tristen Amador, Ph.D., MSW. The study will be done at the Denver Inner City Parish in Denver, Colorado.

Basis of Subject Selection

You are invited to participate because you are male or female, 18 years of age or older, and you are a low-income Latino who speaks English. Also, you reside in metro Denver, Colorado.

Purpose of the Study

The purpose of this research project is to understand what social services Latinos need, as well as Latino perceptions regarding access to social services.

Explanation of Procedures

You will be part of a focus group of five to eight participants. You will be asked interview questions regarding your experiences with accessing social services and why you access social services. The purpose of a focus group is for the moderator (Marissa Kaesemeyer) to create conversation about this topic.

Potential Risks and Discomforts

During the study, it is possible there will be questions you are uncomfortable answering in this study. If this occurs, please answer only the questions you are comfortable with.

Potential Benefits

The results of this study will tell us what Latinos' needs and experiences are in accessing social services. You will receive no benefit from participating in this study other than the opportunity to share your thoughts on this subject.

Financial Obligations

The only expense you will have is transportation to and from Denver Inner City Parish. Parking is available for free on the streets around Denver Inner City Parish.

Assurance of Confidentiality

Your name will not be traced to the data. Your data will be identified only by a false name. Information we get from this study may be published in professional journals or presented at professional meetings. In such publications or presentations, your identity will never be revealed.

Withdrawal from the Study

Participation is voluntary. Your decision whether to participate or not will not affect present or future access to services at Denver Inner City Parish. If you decide to participate, you are free to withdraw from the study at any time without prejudice from the researchers.

Offer to Answer Questions

If you have any questions now or at any time during the study, please ask them. If you have questions after this study, please call Marissa Kaesemeyer or Tristen Amador. If you have any questions concerning your rights as a subject, you may contact Regis University Institutional Review Board at (303) 964-3616.

Printed Name of Subject

Signature of Subject

Date

IN MY JUDGEMENT THE SUBJECT IS VOLUNTARILY AND KNOWINGLY GIVING INFORMED CONSENT AND POSSESSES THE LEGAL CAPACITY TO GIVE INFORMED CONSENT TO PARTICPATE IN THIS RESEARCH STUDY.

Signature of Investigator

Date

Investigators: Primary Investigator, Marissa Kaesemeyer (303) 489-6935 and Faculty Advisor, Tristen Amador (303) 458-4146

Regis University Research Study

Social Service Needs and Perceptions of Low-Income Latinos in Metro Denver

The purpose of this research project is to understand what social services Latinos need, as well as Latino perceptions regarding access to social services.

What it takes to participate:

- Male or female
- Latino
- English-speaking
- 18 years and older
- Low-income
- Live in Denver metro area

**Location of Research Study:
Denver Inner City Parish Conference Room**

**The researcher will conduct a group interview of
5 to 8 participants at a time.
The group interview will last 1- 1 1/2 hours.**

If you have any questions or concerns please contact:

Marissa Kaesemeyer/Principal Researcher (303) 489-6935
Tristen Amador/Faculty at Regis University (303) 458-4146
Regis University, Health Services Administration Dept.